Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY SPECIALTY HOSPITALS OF AMERICA SE
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
TRAVELERS INDEMNITY COMPANY

Carrier's Austin Representative Box
Box Number 5

MFDR Tracking Number
M4-10-1704-01

MFDR Date Received
November 12, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider does request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $14,825.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider is not entitled to additional reimbursement for the spinal fusion portion of the procedure. According to the Medicare coding edits, spinal fusion procedures are not authorized to be performed in an out-patient setting. Specifically, under the Medicare requirements, CPT codes 22554, 63081, 22845, 20931, and 20974 are not authorized out-patient procedure codes. Rule 134.203 mandates the use of the Medicare coding and reimbursement methodologies. As the procedures are not authorized for out-patient application, the Provider improperly provided these services in an out-patient setting. Consequently, the Provider Is not entitled to reimbursement for these procedures, based on the violation of the Medicare site of service requirements. . . . Additionally, as discussed in more detail above, the spinal fusion surgery is not authorized to be performed in an out-patient setting per the Medicare edits, and consequently the Provider is not entitled to reimbursement for the implantables associated with this unauthorized procedure."

Response Submitted by: William E. Weldon, Staff Attorney for TDI-DWC Services, David Klosterboer & Associates, 1501 S. Mopac Expressway, Suite A320, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2008	Outpatient Hospital Services	$14,825.64	$9,007.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - INCL – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE.
   - TXPF – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. THIS SERVICE IS RE-PRICED ACCORDING TO THE TX PHYSICIAN FEE SCHEDULE.
   - TXPK – 97 - PMT ADJUSTED BECAUSE THE BENEFIT FOR THIS SVC IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THAT HAS ALREADY BEEN ADJUDICATED. PYMT INCL IN APC RATE PER TX HOSP MEDICARE METHODOLOGY PER RULE 134.403(D).
   - TXAP – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.
   - TXBP – 125 - PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). THIS PROCEDURE CODE MUST BE BILLED WITH THE PROPER TYPE OF BILL CODE PER RULE 134.403(D).
   - GL10 – 89 - PROFESSIONAL FEES REMOVED FROM CHARGES. SERVICES BILLED FOR RADIOLOGY, LAB, AND /OR PATHOLOGY BY A HOSPITAL SHOULD NORMALLY BE BILLED AT THE TC RATE.
   - FEES – W1 - WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S. OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - TXPC – 199 - REVENUE CODE AND PROCEDURE CODE DO NOT MATCH. THIS PROCEDURE CODE MUST BE BILLED WITH A CORRECT PROCEDURE CODE PER RULE 134.403(D).
   - TXNC – 96 - NON COVERED CHARGE(S). NON COVERED SERVICES PER THE TX HOSPITAL MEDICARE METHODOLOGY PER RULE 134.403(D).
   - P26G – W3 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDITIONAL INFORMATION RECEIVED, AN ADJUSTMENT IS BEING MADE TO THE ORIGINAL TOTAL INVOICE.

Issues

1. Did the insurance carrier support its reasons for denying the disputed implantable items?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. Was the requestor entitled to perform any of the disputed services in an alternative facility setting?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. What is the additional recommended payment for the implantable items in dispute?
7. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed implantable items with reason code INCL – "W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE." Per 28 Texas Administrative Code §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." The health care provider requested separate reimbursement of implantables; therefore, the implantable items are not packaged services and payment for the implantables is not included in the APC rate. This denial reason is not supported.

Additionally, the respondent's position statement asserts that that "the spinal fusion surgery is not authorized to be performed in an out-patient setting per the Medicare edits, and consequently the Provider is not entitled to reimbursement for the implantables associated with this unauthorized procedure." No documentation was found to support the respondent's assertion that implantable items for which separate reimbursement has been requested under §134.403(f)(1)(B) are not reimbursable when an associated surgery is not payable under Medicare payment policies. Moreover, per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that this denial reason was presented to the requestor before the date the request for dispute resolution was filed. Therefore, this new denial reason or defense shall not be considered in this review.

2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. Medicare policy requires that procedure codes 22554, 63081, 22845, and 20931 be performed only in an inpatient hospital setting. Medicare does not pay for these services when performed in an outpatient setting, and does not assign a payment amount. 28 Texas Administrative Code §134.403 requires, in pertinent part, that "(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process. (j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). (1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include: (A) the reimbursement amount; (B) a description of the services to be performed under the agreement; (C) any other provisions of the agreement; and (D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement." Review of the submitted information finds that, although preauthorization for outpatient treatment was found for procedure codes 63081, 22554, 22845, and 20931, no documentation was found to support that a specific payment amount was approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process. No signed agreement to perform the disputed services in an outpatient setting was submitted by either party. The Division concludes that the requestor did not meet the requirements of §§ 134.403(i) and (j) for performing disputed services in an alternative facility setting; therefore, the Medicare restriction shall apply.
4. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $48,457.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
5. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Per Medicare policy, procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.

- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.31. 125% of this amount is $4.14. The recommended payment is $4.14.
- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.31. 125% of this amount is $4.14. The recommended payment is $4.14.
- Procedure code 76000 has a status indicator of Q, which denotes packaged services that may be separately payable only if OPPS criteria are met. Payment for procedure code 76000 is packaged into the payment for any other services with status indicators S, T, V, or X that are billed on the same date of service. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for other status indicator T and X procedures billed on the same date of service. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
- Procedure code 72020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $26.28. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $44.00. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $44.00. This amount multiplied by 130% yields a MAR of $57.20.
- Procedure code 22554 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. As discussed above, the requestor did not meet the requirements for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 63081 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. As discussed above, the requestor did not meet the requirements for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 22845 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. As discussed above, the requestor did not meet the requirements for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 22851 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0049, which, per OPPS Addendum A, has a payment rate of $1,354.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $812.82. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $803.88. The non-labor related portion is 40% of the APC rate or $541.88. The sum of the labor and non-labor related amounts is $1,345.76. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.205. This ratio multiplied by the billed charge of $1,245.83 yields a cost of $255.40. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,345.76 divided by the sum of all APC payments is 89.87%. The sum of all packaged costs is $6,744.11. The allocated portion of packaged costs is $6,060.66. This amount added to the service cost yields a total cost of $6,316.06. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $3,960.98. 50% of this amount is $1,980.49. The total APC payment for this service, including outliers and any multiple procedure discount, is $3,326.25. This amount multiplied by 130% yields a MAR of $4,324.13.
- Procedure code 20931 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. As discussed above, the requestor did not meet the requirements for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 20974 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $58.42. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $81.03. The recommended payment is $81.03.

- Procedure code 97530 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $28.93. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $40.13. The recommended payment is $40.13.
- Per Medicare policy, procedure code 97116 is unbundled. This service is a component procedure of procedure code 97530 performed on the same date of service. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $70.20. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $97.37. The recommended payment is $97.37.
- Per Medicare policy, payment for procedure code 99071 is included in the payment for other services performed on the same date. Separate reimbursement is not recommended.
- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $21.46. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.92. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $35.92. This amount multiplied by 130% yields a MAR of $46.70.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $21.46. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.92. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $35.92. This amount multiplied by 130% yields a MAR of $46.70.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $21.46. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.92. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $35.92. This amount multiplied by 130% yields a MAR of $46.70.
- Procedure code A9300 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

6. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   - "EBI BONE GROWTH STIM" as identified in the itemized statement and labeled on the invoice as "EXTERNAL BONE GROWTH STIMULATOR - LUMBAR" with a cost per unit of $4,200.00;
   - "PUTTY DBM" as identified in the itemized statement and labeled on the invoice as "ALPHA GRAFT BONE MATRIX PUTTY 5CC" with a cost per unit of $685.00;
   - "DISTRACTION PIN 12MM" as identified in the itemized statement and labeled on the invoice as "CASPAR DISTR PIN 12MMSTER" with a cost per unit of $776.00 at 2 units, for a total cost of $1,552.00;
   - "PLATE SPIDER CERV" as identified in the itemized statement and labeled on the invoice as "28 mm Single Level Plate" with a cost per unit of $2,310.00;
   - "SCREW CERV SPIDER" as identified in the itemized statement and labeled on the invoice as "4 mm x 14 mm Fixed Screw" with a cost per unit of $395.00 at 4 units, for a total cost of $1,580.00;
   - "SCREW CERV SPIDER" as identified in the itemized statement and labeled on the invoice as "4 mm x 14 mm Variable Screw" with a cost per unit of $395.00 at 2 units, for a total cost of $790.00;
   - "SPACER 6MM X-SMALL" as identified in the itemized statement and labeled on the invoice as "NOVEL XS M, 6MM, PEEK" with a cost per unit of $2,178.00.

   The total net invoice amount (exclusive of rebates and discounts) is $13,295.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,329.50. The total recommended reimbursement amount for the implantable items is $14,624.50.

7. The total recommended payment for the services in dispute is $19,372.73. This amount less the amount previously paid by the insurance carrier of $10,365.37 leaves an amount due to the requestor of $9,007.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9,007.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,007.36, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 5, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.